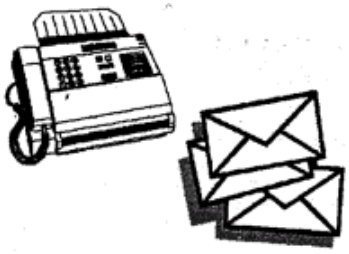
CONFIDENTIAL CASE REPORT



Communicable Disease Program
Montana Department of Public Health & Human Services
Cogswell Building, Room C-216
Helena, MT 59620

Phone: (406) 444-0273 Fax: (800) 616-7460

Instructions: Please complete a form for each case of a communicable disease listed in 37.114.203 of the Administrative Rules of Montana (ARM).

*** If you are reporting a case of Gonorrhea, Chlamydia, or Syphilis, it is necessary to complete only the back of this form.**

After completion, fax or mail this form to the number or address listed above and keep a copy for your records. You may also call the above number for a list of reportable diseases, additional reporting forms, or to receive more information.

Thank you for your cooperation with disease reporting!

INDIVIDUAL CASE REPORT

CASE INFORMATION

Disease/Condition: ☐ Suspected ☐ Confirmed				
Date of Onset:		Lab Result/Diagnosis Date:		
Specimen Collection Date:		Date Reported to Health Dept:		
Patients Name:			Occupation:	
Phone:	DOB:	Age:	Sex:	Race:
Address:		City:		County:

PROVIDER INFORMATION

Physician/Care Provider:
City:
Contact for more info:

COMMENTS:_____

_____

_____

_____

_____

_____

_____

Local Health Dept. Reviewer:

Complete This Side For Gonorrhea, Syphilis, or Chlamydia

CONFIDENTIAL SEXUALLY TRANSMITTED DISEASE CASE RECORD

PATIENT INFORMATION

Name:			DOB:
Address:			Phone:
City:		County:	Zip:
Age:	Sex: M F	Race: White Black American Indian Asian Hispanic Unknown	

SPECIMEN COLLECTION/CLINICAL DIAGNOSIS

Name of Lab Performing Test: MTPHL or :		
Date Lab Specimen Collected:	Test Type: Probe EIA Culture Amplified	
Date Lab Report Received:	Date Reported to Health Department:	
Patient Diagnosis:		PID: Yes No
Health Care Provider:		Phone:
Provider's Address:		

PATIENT TREATMENT INFORMATION

Date:	Med:	Dose:	Duration:
Date:	Med:	Dose:	Duration:

CONTACT INTERVIEW

Interviewer:	Date:
Interviewing Agency:	

CONTACT INFORMATION

Name of Contact	Sex	Date of Last Exposure	Test Date	Date of Treatment	Disposition Code *(See Below)*

ADDITIONAL INFORMATION

Was patient counseled about HIV risk?	Yes	No	Date if Known:
Was patient tested for HIV?	Yes	No	Date if Known:

DISPOSITION CODES

A. Preventive Treatment
B. Refused Preventive Treatment
C. Infected, Brought to Treatment
D. Infected, Not Treated
E. Previously Treated for this Infection
F. Not Infected
G. Insufficient Information to Begin Investigation
H. Unable to Locate
J. Located, Refused Examination
K. Out of Jurisdiction

Comments: _____

Local Health Department Reviewer: _____ ~ New Case ~ Update of prior report	If out of jurisdiction: Case Referred to DPHHS ~ or County ~_____